		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041509

Facility Name: Heritage Manor-Carlinville

Address: 1200 UNIVERSITY AVENUE (Number) Carlinville (City) 62626 (Zip Code)

County: Macoupin

Telephone Number: (217) 854-4433 **Fax #** ( )

IDPA ID Number: 370909086006

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Craig L. Ater
(Title) Senior V.P. and Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,986	6,316	3,587	26,889	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	16,986	6,316	3,587	26,889	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.03%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,587

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	137,397	8,038		145,435		145,435	4,033	149,468			1
2	Food Purchase		125,184		125,184		125,184		125,184			2
3	Housekeeping	62,591	13,078		75,669		75,669		75,669			3
4	Laundry	38,803	14,814		53,617		53,617		53,617			4
5	Heat and Other Utilities			93,718	93,718		93,718	1,235	94,953			5
6	Maintenance	34,888	32,168	19,965	87,021		87,021	14,464	101,485			6
7	Other (specify):*											7
8	**TOTAL General Services**	273,679	193,282	113,683	580,644		580,644	19,732	600,376			8
	B. Health Care and Programs											
9	Medical Director			2,822	2,822		2,822		2,822			9
10	Nursing and Medical Records	1,141,277	49,923	10,497	1,201,697		1,201,697		1,201,697			10
10a	Therapy		233,032	274,970	508,002	(516,730)	(8,728)	269,833	261,105			10a
11	Activities	55,754	2,237		57,991		57,991		57,991			11
12	Social Services	24,084		3,430	27,514		27,514		27,514			12
13	Nurse Aide Training	4,463	1,975		6,438		6,438	2,136	8,574			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,225,578	287,167	291,719	1,804,464	(516,730)	1,287,734	271,969	1,559,703			16
	C. General Administration											
17	Administrative	58,603			58,603		58,603	72,611	131,214			17
18	Directors Fees							5,871	5,871			18
19	Professional Services			222,961	222,961		222,961	(203,000)	19,961			19
20	Dues, Fees, Subscriptions & Promotions			88,730	88,730	(59,292)	29,438	(12,466)	16,972			20
21	Clerical & General Office Expenses	68,551	5,890	22,731	97,172		97,172	146,165	243,337			21
22	Employee Benefits & Payroll Taxes			314,229	314,229		314,229	37,652	351,881			22
23	Inservice Training & Education			740	740		740	597	1,337			23
24	Travel and Seminar			5,080	5,080		5,080	(3,081)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,169	62,169		62,169	2,204	64,373			26
27	Other (specify):*			18,000	18,000		18,000	(18,000)				27
28	**TOTAL General Administration**	127,154	5,890	734,640	867,684	(59,292)	808,392	28,553	836,945			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,626,411	486,339	1,140,042	3,252,792	(576,022)	2,676,770	320,254	2,997,024			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Carlinville #0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			111,102	111,102		111,102	12,556	123,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			166,305	166,305		166,305	(572)	165,733			32
33	Real Estate Taxes			40,378	40,378		40,378		40,378			33
34	Rent-Facility & Grounds							7,148	7,148			34
35	Rent-Equipment & Vehicles			4,038	4,038		4,038	2,814	6,852			35
36	Other (specify):*											36
37	**TOTAL Ownership**			321,823	321,823		321,823	21,946	343,769			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					516,730	516,730		516,730			39
40	Barber and Beauty Shops		119	6,369	6,488		6,488		6,488			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					59,292	59,292		59,292			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		119	6,369	6,488	576,022	582,510		582,510			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,626,411	486,458	1,468,234	3,581,103		3,581,103	342,200	3,923,303			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(572)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,068)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,905)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,051)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)	27		24
25	Fund Raising, Advertising and Promotional	(15,366)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,962)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	394,162		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 394,162		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 342,200		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor-Carlinville

ID# 0041509

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(1,068)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(5,051)	19	22
23				23
24		(18,000)	27	24
25		(15,366)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(39,485)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,033	0	0	0	0	0	0	0	0	4,033	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,235	0	0	0	0	0	0	0	0	1,235	5
6	Maintenance	0	0	14,464	0	0	0	0	0	0	0	0	14,464	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	19,732	0	0	0	0	0	0	0	0	19,732	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	269,833	0	0	0	0	0	0	0	0	0	269,833	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	2,136	0	0	0	0	0	0	0	0	2,136	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	269,833	2,136	0	0	0	0	0	0	0	0	271,969	16
	C. General Administration													
17	Administrative	0	0	72,611	0	0	0	0	0	0	0	0	72,611	17
18	Directors Fees	0	0	5,871	0	0	0	0	0	0	0	0	5,871	18
19	Professional Services	(5,051)	(216,410)	18,461	0	0	0	0	0	0	0	0	(203,000)	19
20	Fees, Subscriptions & Promotions	(16,434)	0	3,968	0	0	0	0	0	0	0	0	(12,466)	20
21	Clerical & General Office Expenses	0	0	146,165	0	0	0	0	0	0	0	0	146,165	21
22	Employee Benefits & Payroll Taxes	0	0	37,652	0	0	0	0	0	0	0	0	37,652	22
23	Inservice Training & Education	0	0	597	0	0	0	0	0	0	0	0	597	23
24	Travel and Seminar	(11,905)	0	8,824	0	0	0	0	0	0	0	0	(3,081)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,204	0	0	0	0	0	0	0	0	2,204	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	**TOTAL General Administration**	(51,390)	(216,410)	296,353	0	0	0	0	0	0	0	0	28,553	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,390)	53,423	318,221	0	0	0	0	0	0	0	0	320,254	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	12,556	0	0	0	0	0	0	0	12,556	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(572)	0	0	0	0	0	0	0	0	0	0	(572)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	7,148	0	0	0	0	0	0	0	7,148	34
35	Rent-Equipment & Vehicles	0	0	0	2,814	0	0	0	0	0	0	0	2,814	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(572)	0	0	22,518	0	0	0	0	0	0	0	21,946	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(51,962)	53,423	318,221	22,518	0	0	0	0	0	0	0	342,200	45

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Therapy	100.00%			2
3	V								3
4	V	19	Adjustment for Related Organization	216,410	Heritage Enterprises, Inc.	100.00%		(216,410)	4
5	V								5
6	V	10a	Adjustment for Related Organization	232,664	GreenTree Pharmacy	100.00%	502,497	269,833	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 449,074			$ 502,497	$ * 53,423	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 4,033	$ 4,033	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				0		17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,235	1,235	19
20	V	6	Maintenance				14,464	14,464	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				2,136	2,136	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				72,611	72,611	29
30	V	18	Directors Fees				5,871	5,871	30
31	V	19	Professional Services				18,461	18,461	31
32	V	20	Fees, Subscription, Promotions				3,968	3,968	32
33	V	21	Clerical & General Office Expenses				146,165	146,165	33
34	V	22	Employee Benefits & Payroll Taxes				37,652	37,652	34
35	V	23	Inservice Training & Education				597	597	35
36	V	24	Travel and Seminar				8,824	8,824	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				2,204	2,204	38
39	Total			$			$ 318,221	$ * 318,221	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.		$ 0	$	15
16	V	30	Depreciation				12,556	12,556	16
17	V	31	Amortization of Pre-Op & Org				0		17
18	V	32	Interest				0		18
19	V	33	Real Estate Taxes				0		19
20	V	34	Rent-Facility & Grounds				7,148	7,148	20
21	V	35	Rent-Equipment & Vehicles				2,814	2,814	21
22	V	36	Other				0		22
23	V	38	Medically Nec Transportation				0		23
24	V	39	Ancillary Service Centers				0		24
25	V	40	Barber and Beauty Shops				0		25
26	V	41	Coffee and Gift Shops				0		26
27	V	42	Other				0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 22,518	$ * 22,518	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86		10		Salary/BOD	$ 3,593	Ln. 17/18	1
2	Tom Jefferson	Secretary	Management	16.21		10		Salary/BOD	15,419	Ln. 17/18	2
3	Craig Hart	Chairman	Management	31.95		10		Salary/BOD	19,523	Ln. 17/18	3
4	Cheryl Lowney	Executive Vice Presid	Management	0.49		40	100.00	Salary/BOD	10,620	Ln. 17/18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	14,166	Ln. 17/18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	7,041	Ln. 17/18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	8,120	Ln. 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 78,482		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,403	24	$ 89,729	$ 89,729	108	$ 4,033	1
2	2	Food Purchase	Beds	2,403	24	0	0	108	0	2
3	3	Housekeeping	Beds	2,403	24	0	0	108	0	3
4	4	Laundry	Beds	2,403	24	0	0	108	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,471	0	108	1,235	5
6	6	Maintenance	Beds	2,403	24	321,832	76,617	108	14,464	6
7	7	Other	Beds	2,403	24	0	0	108	0	7
8	9	Medical Director	Beds	2,403	24	0	0	108	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	0	108	0	9
10	11	Activities	Beds	2,403	24	0	0	108	0	10
11	12	Social Service	Beds	2,403	24	0	0	108	0	11
12	13	Nurse Aide Training	Beds	2,403	24	47,533	39,159	108	2,136	12
13	14	Program Transportation	Beds	2,403	24	0	0	108	0	13
14	15	Other	Beds	2,403	24	0	0	108	0	14
15	17	Administrative	Beds	2,403	24	1,615,588	1,615,588	108	72,611	15
16	18	Directors Fees	Beds	2,403	24	130,630	0	108	5,871	16
17	19	Professional Services	Beds	2,403	24	410,747	0	108	18,461	17
18	20	Fees, Subscription, Promotions	Beds	2,403	24	88,297	0	108	3,968	18
19	21	Clerical & General Office Expens	Beds	2,403	24	3,252,161	2,929,944	108	146,165	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,403	24	837,746	0	108	37,652	20
21	23	Inservice Training & Education	Beds	2,403	24	13,283	0	108	597	21
22	24	Travel and Seminar	Beds	2,403	24	196,325	0	108	8,824	22
23	25	Other Admin. Staff Transportatio	Beds	2,403	24	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	49,040	0	108	2,204	24
25	TOTALS					$ 7,080,382	$ 4,751,037		$ 318,221	25

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,403	24	$	$	108	$	1
2	30	Depreciation	Beds	2,403	24	279,369		108	12,556	2
3	31	Amortization of Pre-Op & Org	Beds	2,403	24			108		3
4	32	Interest	Beds	2,403	24			108		4
5	33	Real Estate Taxes	Beds	2,403	24			108		5
6	34	Rent-Facility & Grounds	Beds	2,403	24	159,040		108	7,148	6
7	35	Rent-Equipment & Vehicles	Beds	2,403	24	62,608		108	2,814	7
8	36	Other	Beds	2,403	24			108		8
9	38	Medically Nec Transportation	Beds	2,403	24			108		9
10	39	Ancillary Service Centers	Beds	2,403	24			108		10
11	40	Barber and Beauty Shops	Beds	2,403	24			108		11
12	41	Coffee and Gift Shops	Beds	2,403	24			108		12
13	42	Other	Beds	2,403	24			108		13
14								108		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 501,017	$		$ 22,518	25

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	$	$ 2,470,424	01/15/06	variable	$ 134,050	1
2	LsSalle National Bank		xx	Mortgage							20,296	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							11,959	6
7	Central Office Allocation		xx	Working Capital								7
8												8
9	TOTAL Facility Related						$	$ 2,470,424			$ 166,305	9
	B. Non-Facility Related*											
10	Interest Income										(572)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (572)	14
15	TOTALS (line 9+line14)						$	$ 2,470,424			$ 165,733	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	37,833	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	38,151	2
3. Under or (over) accrual (line 2 minus line 1).	$	318	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	40,060	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	40,378	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	32,590	8
	2000	28,390	9
	2001	32,706	10
	2002	35,898	11
	2003	38,496	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Carlinville COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0041509

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-000-264-02		$ 38,151.00	$ 38,151.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,151.00	$ 38,151.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,527 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	land			$ 32,017	1
2					2
3	TOTALS			$ 32,017	3

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108				$ 3,265,145	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Heritage Manor Sign			1996	2,176						9
10	Architect Fees			1996	2,387						10
11	Laundry Room Electrical Repair			1996	3,019						11
12											12
13											13
14	Special Care Unit -- Remodel			1997	30,884						14
15											15
16	Remodel-- Alzheimer Wing			1998	78,813						16
17	A/C Unit			1998	950						17
18	Life Safety Improvements			1998	7,351						18
19	Shower Room Remodel			1998	2,811						19
20	Roof Replacement			1998	92,246						20
21											21
22	Door Alarm			1999	2,317						22
23	Smoke Damperer			1999	498						23
24	Water System			1999	8,115						24
25	Interior Painting--Material and Labor			1999	6,892						25
26	Shower Room Remodel			1999	2,453						26
27	Water Heater			1999	4,253						27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							12,557	12,557		34
35	Book Depreciation					96,020		96,020		774,202	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Softener	2000	$ 3,802	$		$	$	$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	11,232						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,639,121	$ 96,020		$ 108,577	$ 12,557	$ 774,202	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 379,689	$ 15,082	$ 15,082	$		$ 345,224	71
72	Current Year Purchases	8,531						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 388,220	$ 15,082	$ 15,082	$		$ 345,224	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,059,358	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 111,102	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,659	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,557	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,119,426	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,852 Description: pager, computer equipment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,975		1,975
3	Classroom Wages (a)		4,463		4,463
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 6,438	$	$ 6,438
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,438			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 114,187	$		$ 114,187	1
2	Licensed Speech and Language Development Therapist		hrs			38,696			38,696	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			107,878	343		108,221	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				502,521		502,521	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					14,209			14,209	13
14	TOTAL			$		$ 274,970	$ 502,864		$ 777,834	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Carlinville **#** 0041509 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,706	$	1
2	Cash-Patient Deposits	5,646		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	356,211		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,916		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,629,324)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,237,845)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,017		13
14	Buildings, at Historical Cost	3,639,120		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	388,221		16
17	Accumulated Depreciation (book methods)	(1,119,426)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	40,881		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,980,813	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,742,968	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,997	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,646		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	194,878		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,875		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,060		32
33	Accrued Interest Payable	13,515		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 333,971	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,470,424		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,470,424	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,804,395	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,061,427)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,742,968	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (971,141)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (971,141)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(90,286)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (90,286)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,061,427)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,421,989	1
2	Discounts and Allowances for all Levels	(1,056,624)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,365,365	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	708,072	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 708,072	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,646	11
12	Gift and Coffee Shop	2,201	12
13	Barber and Beauty Care	9,770	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	402,869	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 423,486	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	572	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 572	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,497,495	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	580,644	31
32	Health Care	1,804,464	32
33	General Administration	867,684	33
	B. Capital Expense		
34	Ownership	321,823	34
	C. Ancillary Expense		
35	Special Cost Centers	6,488	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		6,678	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,587,781	40
41	**Income before Income Taxes (line 30 minus line 40)****	(90,286)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (90,286)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,440	1,887	$ 36,105	$ 19.13	1
2	Assistant Director of Nursing	1,700	1,882	31,805	16.90	2
3	Registered Nurses	3,258	3,347	70,993	21.21	3
4	Licensed Practical Nurses	14,779	15,948	287,606	18.03	4
5	Nurse Aides & Orderlies	67,466	71,988	701,547	9.75	5
6	Nurse Aide Trainees	600	600	4,463	7.44	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,017	1,142	13,221	11.58	8
9	Activity Director					9
10	Activity Assistants	5,781	6,141	55,754	9.08	10
11	Social Service Workers	1,891	2,038	24,084	11.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,062	16,830	137,397	8.16	15
16	Dishwashers					16
17	Maintenance Workers	2,441	2,628	34,888	13.28	17
18	Housekeepers	11,165	11,788	62,591	5.31	18
19	Laundry	3,268	3,700	38,803	10.49	19
20	Administrator	1,900	2,080	58,603	28.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,355	5,890	68,551	11.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,123	147,889	$ 1,626,411 *	$ 11.00	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		2,822		36
37	Medical Records Consultant		7,531		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,166		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,430		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,949		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barb Varwig			$ 58,603
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,603

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Mgt Fee	$ 216,410
Robert McQuellen	Consulting	1,500
		0
		0
		5,051
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 222,961

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,155
Unemployment Compensation Insurance	23,173
FICA Taxes	124,420
Employee Health Insurance	121,550
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	11,931
Employee Benefits - central office	37,652
TOTAL (agree to Schedule V, line 22, col.8)	$ 351,881

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	503
Health Care Worker Background Check	
(Indicate # of checks performed)	320
Central Office Allocation	3,968
Promotional Advertising	4,955
Public Relations	10,411
Dues and Subscriptions	8,529
License and Fees	4,720
Less: Public Relations Expense	(10,411)
Non-allowable advertising	(1,068)
Yellow page advertising	(4,955)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,972

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,113
	165
Seminar Expense	1,802
	(11,905)
	8,824
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor-Carlinville # 0041509 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,292**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **163**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **Not available at this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.